FSG REIMAGINING SOCIAL CHANGE

Methodist Healthcare Ministries' El Valle Regional Summit

UNIDOS CONTRA DIABETES | SEPTEMBER 10, 2015

Agenda

1. Welcome and Introduction
2. Diabetes in the RGV
3. Unidos Contra Diabetes
4. Overview of collective Impact
5. Where Are We Now?
6. Q & A

Unidos Contra Diabetes steering committee chairs

Belinda Reininger

Mary Valencia

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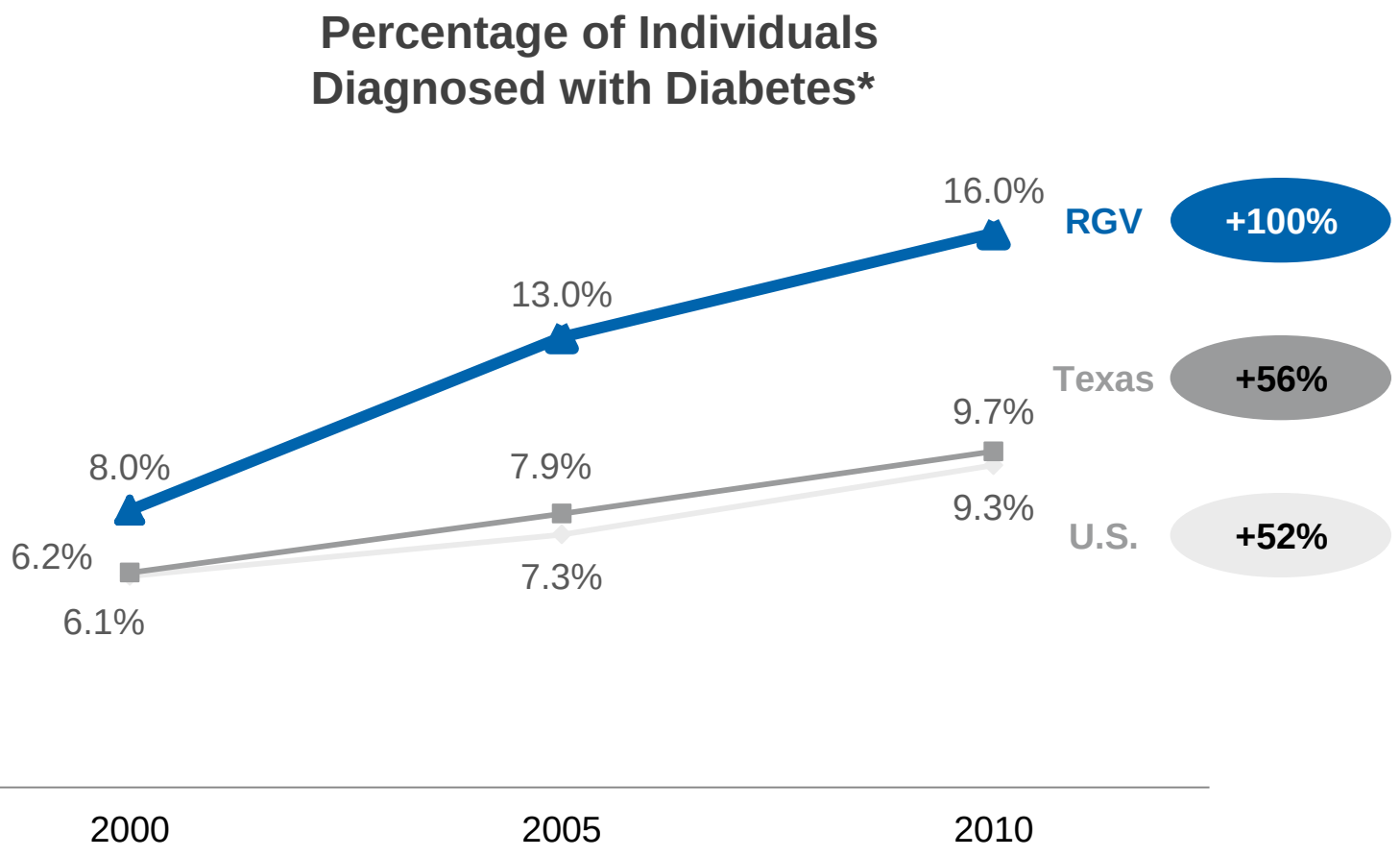
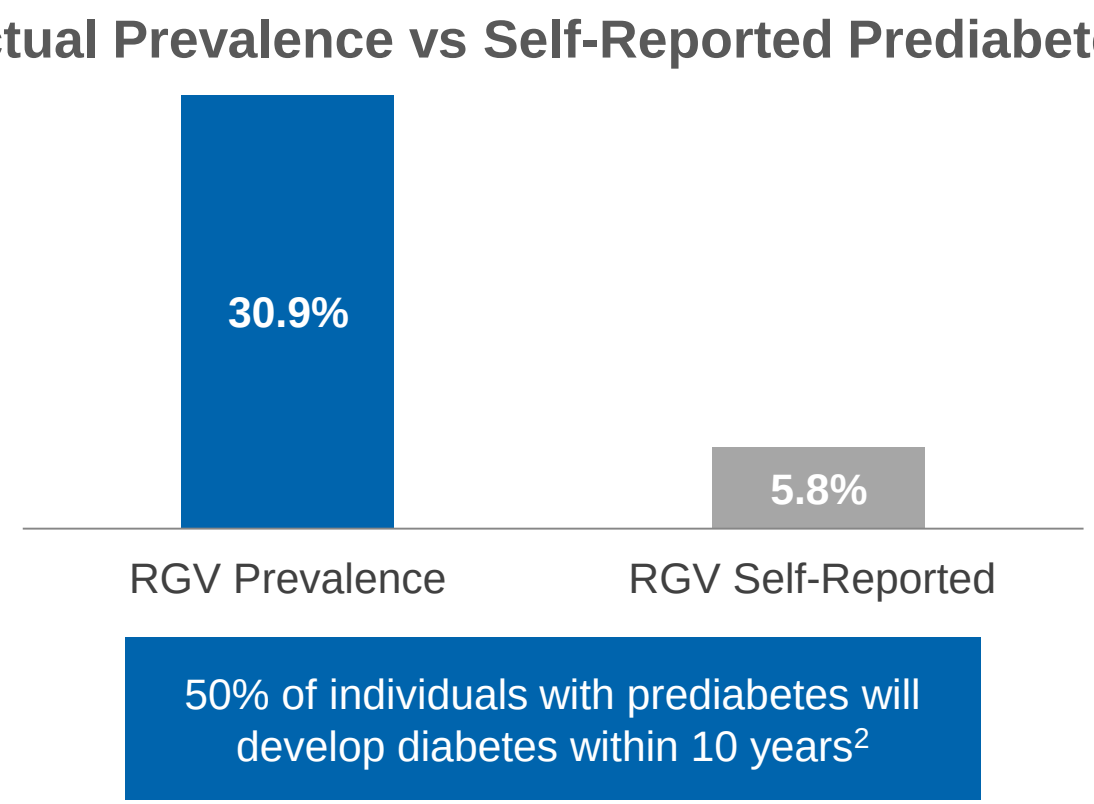
Rates of Diagnosed Diabetes in the RGV have Risen Rapidly and Are Now Alarmingly High



*Note: Texas and U.S. estimates are derived from BRFSS; RGV estimate is derived from U.S. Diabetes Index (USDI); the 16.0% prevalence may be an underestimate as survey results are self-reported; a randomized study of RGV Mexican Americans identified a 31% prevalence rate after confirming diagnosis through a blood test

Sources: USDI, 2010; Texas BRFSS, 2010; "Diabetes in Texas- Prevalence," Texas Diabetes Council, 2009.

Actual rates of prediabetes are much higher than what is self-reported



Intervening at the prediabetes stage can halt the onset of diabetes but will require significant investment in screening and diagnosis

*Note: RGV prevalence estimate is derived from a randomized study of Mexican Americans in Cameron County and RGV self-reported is derived from Texas BRFSS

Very low levels of physical activity and poor diet contribute to these high rates of diabetes

Lack of Physical Activity

- Nearly **60%** of RGV residents **lack access to physical activity**[1]
- Compared to Texas, RGV residents are nearly **1.5X as likely to report no exercise** in the last month[2]

Poor Diet

- Over **40%** of RGV residents have **low food access**[3]
- **80%** RGV residents **do not consume recommended quantity of fruits / vegetables**[4]

High Obesity

Nearly half of RGV Mexican Americans are obese, according to an RGV based study[1]

High Blood Pressure

Nearly **one in three individuals** in the RGV have high blood pressure and **60% are undiagnosed**[2]

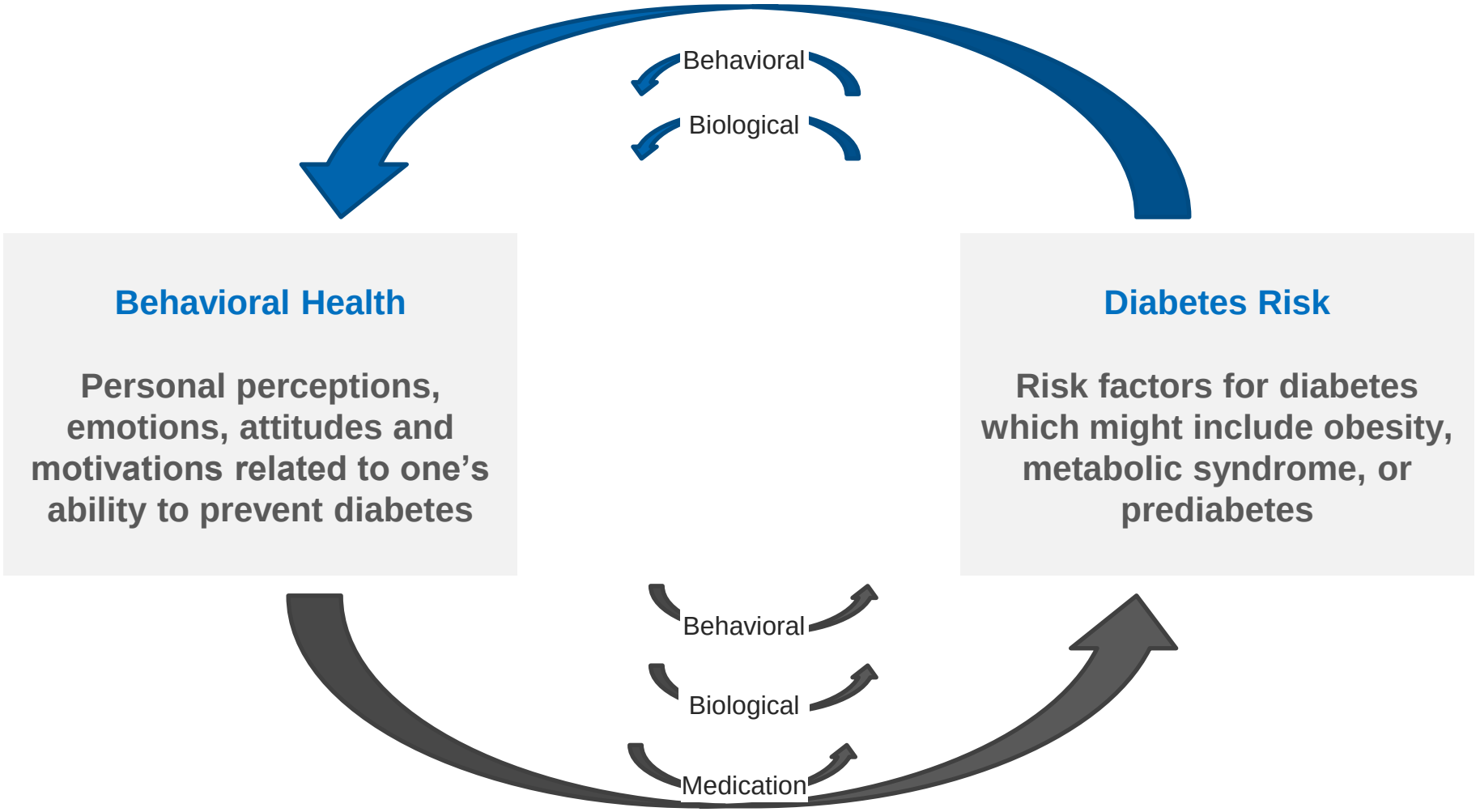
High Cholesterol

Nearly **half of RGV residents have high cholesterol** and **over 80% are undiagnosed**[3]

*Note: Obesity is defined as Body Mass Index ≥30

1. RWJF County Health Ranking Database, 2012..; **2.** Texas BRFSS (McAllen-Edinburg-Pharr metro area), 2010.; **3.** USDA Food Access Research Atlas, 2010, published in Community Commons.; **4.** Texas BRFSS (McAllen-Edinburg-Pharr metro area), 2009.; **5.** Texas BRFSS, RGV Counties, 2012.; **6** ADA, 2014.

The reciprocal relationship between behavioral health and diabetes risk compounds the challenge



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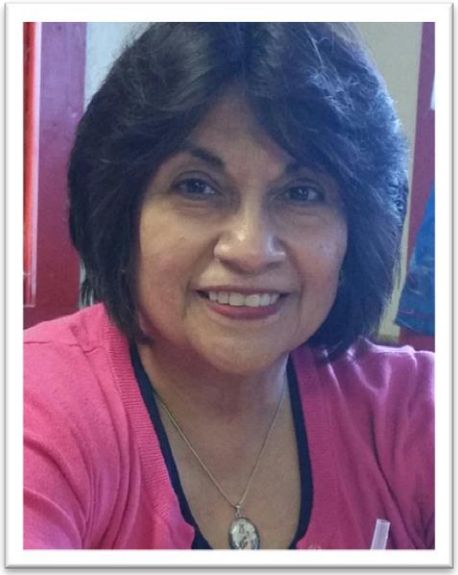
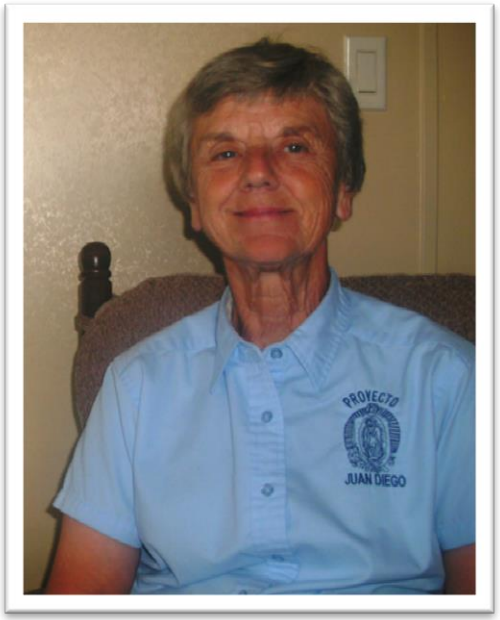
Why did I choose to be part of Unidos Contra Diabetes?



Dalia Tovar
Su Clinica



Sister Phyllis Peters
Executive Director
Proyecto Juan Diego

The root causes of diabetes are multifaceted and cannot be solved by one organization

The residents of the Rio Grande Valley experience a higher rate of diabetes, due to…

…inadequate awareness, expansion, and integration of **existing efforts**

…lack of incentives for **preventative care**,

…not enough people are getting **screened and tested**,

…insufficient **prevention literacy** that would empower people to understand their risk and know what actions to take to lower it,

…inadequate **supports in the community** to make the lifestyle changes needed to prevent diabetes,

…and too few **policies, practices and leaders** supporting the systems changes need to create and sustain culture of health.

We came up with the following goal to guide our work

Our goal is to reduce the number of new cases of type II diabetes in 5 years, resulting in a 10% reduction in the prevalence of diabetes by 2030. We are committed to doing this by integrating primary and behavioral health for people at risk for diabetes in our community, with a particular emphasis on meeting the needs of low-income and underserved populations.

We articulated guiding principles to frame how we have and will continue to work together

Guiding Principles

1. **Serve the whole community through a systems oriented approach** – we support not only the individuals at risk for diabetes, but also their families and the communities they live in. We strive to change the overall system, including policies, practices and culture and norms to create a healthier community
2. **Take an asset-based approach** – we will view all families and individuals as assets to build upon and avoid shaming people for poor health
3. **This is everyone's responsibility** – diabetes prevention is a shared responsibility of the entire community, including the private sector, governments, schools, families, and individuals at risk for diabetes
4. **Think holistically about health** – we believe that supporting health means promoting mind, body, and spiritual wellness
5. **Empower people and families** – we commit to empowering individuals and families with the knowledge and cost-effective care and tools they need to take their health into their own hands

28 organizations, and almost 50 people, have come together to form Unidos Contra Diabetes

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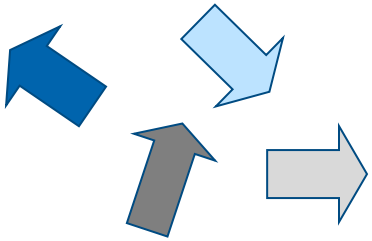
Definition of collective impact

Collective Impact is the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem at scale.

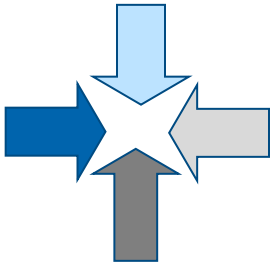
Working together isn't easy – working together is tough and requires sustained dedication

Isolated Impact



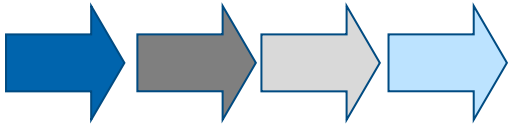
- Initiatives are successful on their own but do not coordinate with one another
- Sense of competition among players
- Both duplication of efforts and gaps in service
- Inability to compare results and track big picture progress

Collaboration / Coalitions



- Agreement and excitement around improving one aspect of the system
- Too often, effort include system actors but exclude community organizations and individuals
- Meetings do not achieve forward momentum or shared accountability

Collective Impact



- A broad, holistic system focus that works towards a shared vision and measures
- Cross-sector actors, previously viewed as competitors, work together to coordinate action and enhance services
- Long term infrastructure supports learning and accountability among actors

The five conditions for collective impact

1 **Common agenda**	All participants share a vision for change that includes a **common understanding of the problem** and a joint approach to solving the problem through agreed-upon actions
2 **Shared measurement system**	All participants agree on how to measure and report on progress, with a **short list of common indicators** identified and used to drive learning and improvement
3 **Mutually reinforcing activities**	A diverse set of stakeholders, typically across sectors, **coordinate a set of differentiated activities** through a mutually reinforcing plan of action
4 **Continuous communication**	All players engage in **frequent and structured** open communication to build trust, assure mutual objectives, and create common motivation
5 **Backbone support**	An **independent, dedicated staff (with funding!)** guides the initiative's vision and strategy, supports aligned activities, establishes shared measurement practices, builds public will, advances policy, and mobilizes resources

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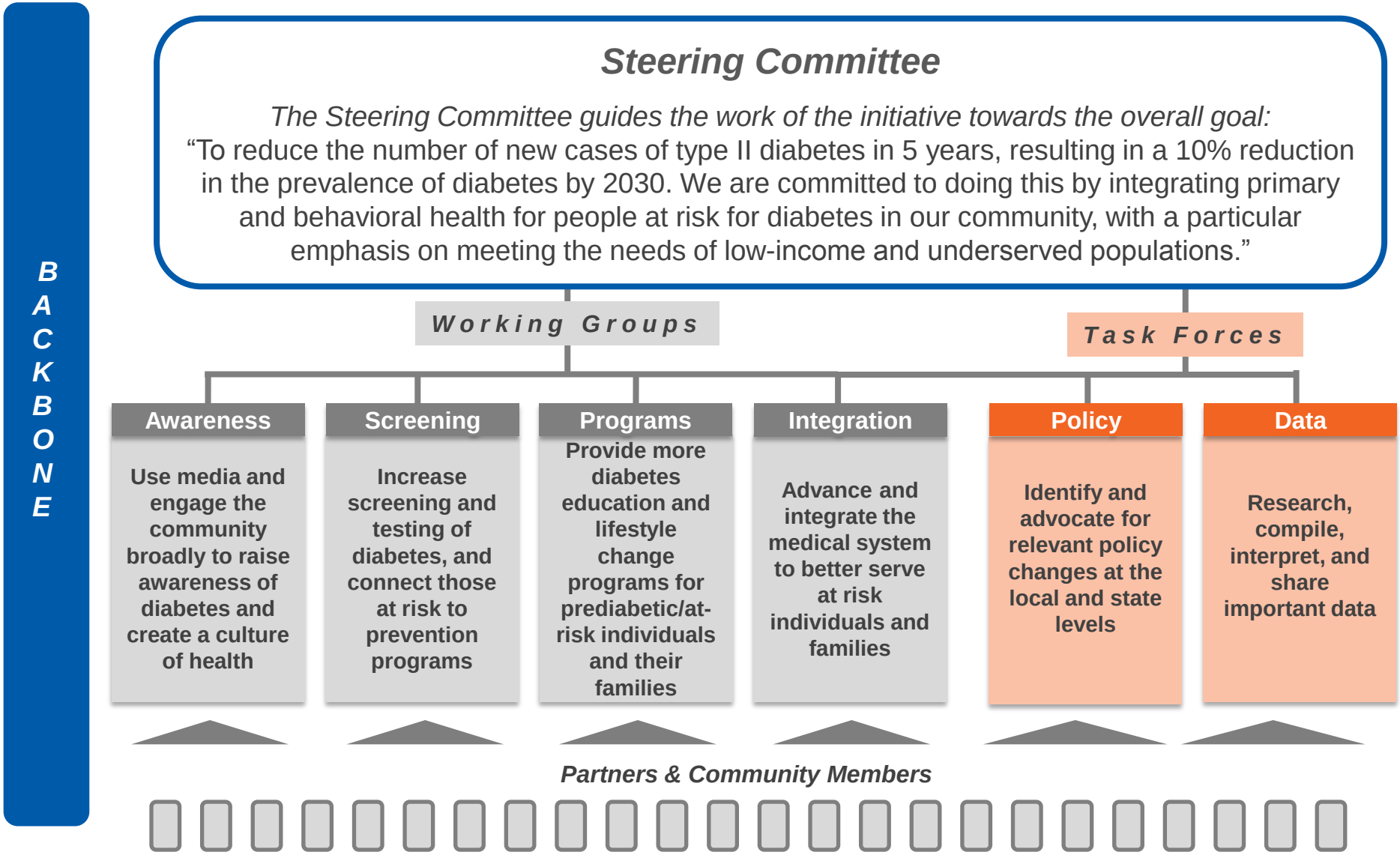
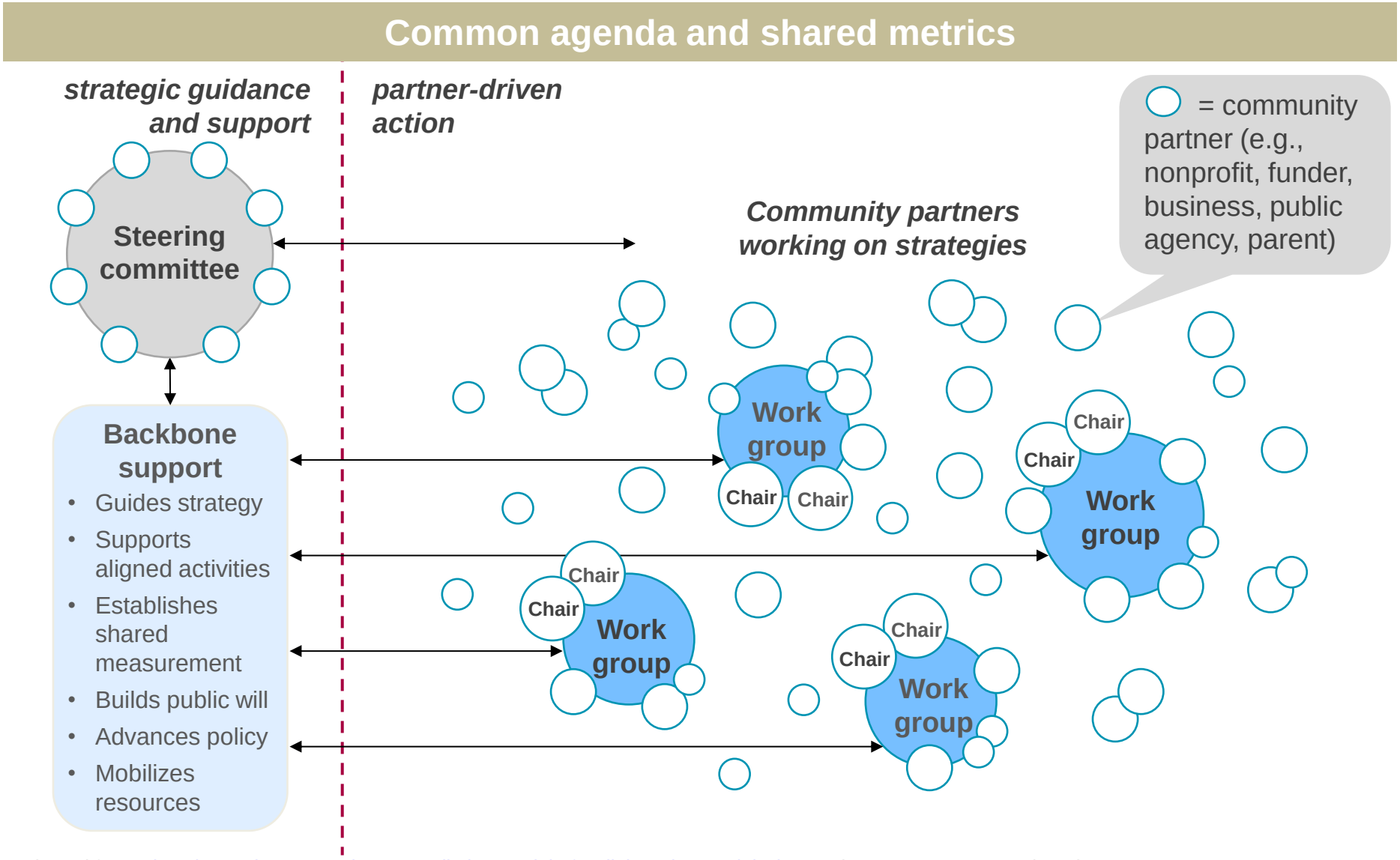
The effort is made up of a backbone, steering committee, working groups, and task forces



Collective impact transpires over five phases

Components for Success	Phase I Assess Readiness	Phase II Initiate Action	Phase III Organize for Impact	Phase IV Begin Implementation	Phase V Sustain Action and Impact
Governance and Infrastructure	Convene community leaders	Identify champions and form cross-sector Steering Committee "SC" to guide the effort	Determine initial workgroups and plan backbone organization	Launch work groups "WGs" and select backbone organization	Building out the backbone organization; evolve WGs to meet emergent strategy
Strategic Planning	Hold dialogue about issue, community context, and available resources	Map the landscape and use data to make case	Create common agenda, clear problem definition, population level goal	Develop Blueprint for Implementation; identify quick wins	Refine strategies; mobilize for quick wins
Community Engagement	Determine community readiness; Create a community engagement plan	Begin outreach to community leaders	Incorporate community voice - gain community perspective and input around issue	Engage community more broadly and build public will	Continue engagement and conduct advocacy
Evaluation And Improvement	Determine if there is consensus/urgency to move forward	Analyze baseline data to ID key issues and gaps	Develop high level shared metrics and/or strategies at SC level	Establish shared measures (indicators and approach) at SC and WG levels	Collect, track, and report progress (process to learn and improve)

Collective Impact in action looks like this



* Adapted from *Listening to the Stars: The Constellation Model of Collaborative Social Change*, by Tonya Surman and Mark Surman, 2008.

Shared Measurement – members of the group developed consensus on three criteria for measure selection

1. Measure **provides meaningful insights** (e.g., evidence base exists) into whether the effort is making progress in preventing diabetes

2. Measure is **publicly available** at the population level, **comparable across counties/demographics** and **collected regularly** by a **trusted source**

3. Measure is **able to be influenced to a significant degree by the working groups**

Not all three criteria need to apply to every measure

The data group recommended a subset of potential shared measures

Healthy Community

- **Adequate access to locations for physical activity, *RWJF***
- **Adequate access to healthy food, *RWJF***
- # of miles of trails
- # of parks
- City resources dedicated to parks
- # of businesses offering wellness programs
- Access to exercise venues
- Policies for safe streets/sidewalks
- Access to healthy food
- # of community gardens
- Access to regular preventative care
- % of population with access to care

Health Behaviors

- **Portion control, *need data source***
- **Fruit and vegetable consumption, *BRFSS***
- **Soda and fast food consumption, *BRFSS***
- **Any physical activity, *BRFSS***
- **Min of physical activity, *BRFSS***
- **% meeting physical activity guidelines, *BRFSS***
- Sedentary time
- # of people using trails (2x)
- # of times with physical activity
- % of population meeting physical activity guidelines (2x)
- Screen time
- Awareness of diabetes risk factors
- # of people exposed to diabetes education
- % of population with test for high blood sugar

Risk Factors

- **Overweight / Obesity, *BRFSS***
- **Prediabetes, *BRFSS***
- **Metabolic risk (blood pressure, cholesterol and triglycerides), *Healthy People 2020***
- **% of persons at high risk for diabetes with prediabetes who report trying to lose weight, *Healthy people 2020***
- **# of days of poor mental health during the past 30 days, *BRFSS***
- **# of days during the past 30 days that poor mental health kept an individual from doing usual activities, such as self-care, work, or recreation, *BRFSS***
- Waist to hip ratio
- Childhood obesity

These indicators align very well with the 4 “shared measures” chosen by Sí Texas grantees

Sí Texas grantees chose to collectively measure:

- **Diabetes** – via A1C levels
- **Obesity** – via BMI levels
- **Blood Pressure**
- **Depression** – via the PHQ-9

Developing Next Steps: Quick Wins

What is a quick win?

- A strategy in which you expect implementation and outcomes **in next 6-12 months.**
- It is possible to **measure** progress for learning (i.e., output of work)
- Requires a **little to no extra financial resources**
- Can be accomplished by **the partners currently at the table** doing things differently (e.g., aligning activities, enhancing services)

Awareness:

- (Short Term) Use media and events to spread awareness of diabetes and diabetes risk factors
  - Media campaign strategy to include social media, radio, television, and a website

Screening:

- (Short Term) Collect and share data to identify screening best practices
  - Demographic coordination to enhance follow-up (use Programs WG list as a starting place)

Lifestyle:

- (Short Term) Scale promotora and lifestyle coach programs
  - Group Lifestyle Balance (DPP) Train the Trainer

Medical Integration:

- Train medical professionals to better and more consistently treat those who are at risk or have prediabetes
  - Templates for diabetes risk and depression screening
  - Brief screening tools to identify follow-up resources

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